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**Non-citizen access to anti-retroviral  
treatment in Johannesburg**

**Presented by Joanna Vearey**

Forced Migration Studies Programme, University of the Witwatersrand

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# Migration, access to ART, and survivalist livelihood strategies in Johannesburg

Joanna Vearey

*Forced Migration Studies Programme, University of the Witwatersrand, PO Box 76, Johannesburg 2050, South Africa*  
Author's e-mail: [jovearey@gmail.com](mailto:jovearey@gmail.com)

Since the end of apartheid, patterns of migration into South Africa have shifted, and South Africa has become a destination for people from across the African continent and beyond — a small but important number of whom are refugees and asylum seekers. While South Africa has a protective, integrative, urban refugee policy, many of these individuals struggle to access the rights to which they are entitled, including healthcare. In addition, many lower-skilled international migrants are unable to legalise their stay in South Africa. As a result, international migrants often become part of the group of 'urban poor,' falling within the periphery of health and social welfare provision and relying on a survivalist livelihood within the informal economy. The health and wellbeing of an individual impact greatly on their ability to maintain a secure livelihood, and this becomes more difficult in the context of an HIV epidemic. This paper presents findings from a case study situated in the City of Johannesburg. The research made use of 1) 2006 survey data on migrant livelihood strategies in Johannesburg, 2) a study investigating non-citizens' access to antiretroviral treatment (ART) in the inner city, which included 3) a set of interviews conducted with migrant ART clients who were working in the city's informal economy. The findings indicate (a) the importance of the informal economy for migrants to Johannesburg; (b) the challenges that non-citizens face in accessing ART in the public sector in South Africa; and (c) the linkages between urban migrants' access to ART and their ability to maintain a survivalist livelihood. The paper argues that upholding people's right to ART for all who need it within South Africa will enable international migrants (including refugees and asylum seekers) to maintain an otherwise fragile survivalist livelihood, and this in turn will assist their self-reliance and integration into urban life. Recommendations are made to ensure that the right to healthcare is upheld for all in South Africa.

**Keywords:** equity, government policy, health services, HIV/AIDS, informal sector, local government, public health sector, refugees, South Africa, urban health care

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## Introduction

An urbanising world presents challenges to local urban authorities in developing countries. Migration is recognised as a determinant of health (MacPherson & Gushulak, 2001; Anarfi, 2005) and persistent in-migration contributes to a range of urban health needs (Harpham & Tanner, 1995; Harpham & Molyneux, 2001; MacPherson & Gushulak, 2001; Waelkens & Greindl, 2001; Galea & Vlahov, 2005). As migration to urban areas continues, provincial and local governments in developing countries must design and implement policies to protect the group of 'urban poor' who currently experience a range of deprivations (Mitlin & Satterthwaite, 2004). This group includes rural-to-urban and cross-border migrants, and — in the case of South Africa — asylum seekers and refugees.

The HIV epidemic presents additional contextual and public health challenges to South African urban environments. Sub-Saharan Africa is the most affected region in the world; home to just 10% of the world's population, it has almost 70% of all people infected with HIV (UNAIDS, 2007). In South Africa, 5.5 million people are estimated to be living with HIV, the largest number in any single country,

with adult prevalence estimated at 18.8% (UNAIDS, 2007). South Africa began to roll-out a national antiretroviral treatment (ART) programme in 2004, and the responsibility for this roll-out currently sits with the provincial government.

In South Africa, a progressive, integrative, urban refugee policy exists alongside a restrictive Immigration Act. The Refugees Act, Act 130 of 1998 (Republic of South Africa [RSA], 1998a), affords particular rights through protective legislation to refugees and asylum seekers. This includes the right to employment and access to social services, including basic healthcare. Recent legislation has confirmed that this also includes access to free ART for those needing it (Department of Health, 2007a). However, many challenges are experienced by refugees and asylum seekers as a protective policy has not transformed into protective practices (Landau, 2006a). A central challenge relates to the Department of Home Affairs, since many individuals are unable to access official documentation (Landau, 2006a). The Immigration Act (RSA, 2002) and Immigration Amendment Act (RSA, 2004) make it difficult for less-skilled migrants to legalise their stay in South Africa (Landau, 2004). As a result, and regardless of their documentation status, many international migrants rely on

survivalist livelihoods<sup>1</sup> within the informal economy (Bailey, 2004; De Vriese, 2006; Jacobsen, 2006; Landau, 2006a). Additionally, such individuals have reported challenges in accessing healthcare (Pursell, 2004), including ART (Consortium for Refugees and Migrants in South Africa [CoRMSA], 2007).

Considering the protection legislated to cross-border migrants in South Africa, and the challenges experienced in accessing public health services and sustainable livelihoods in the context of HIV, this paper presents research that investigates the linkages between access to ART and survivalist livelihood strategies as employed by HIV-positive cross-border migrants, including refugees and asylum seekers. The City of Johannesburg is used as a case study.

In South Africa, 56% of the population is now urban (Kok & Collinson, 2006) and this difference is set to increase (UNFPA, 2007). It is essential that local urban governments plan for and implement effective developmental responses to the persistent urban challenges of migration and HIV to ensure that the health of the increasing population of urban poor is achieved and maintained. South African local government has a developmental mandate that should assist in the provision of such a response (see RSA, 1998b). However, various challenges have been reported in the context of local urban governments in regard to the realisation of such a mandate (see Harrison, 2006; Nel & John, 2006).

Making use of previous work on the application of a livelihoods approach to urban refugees (see Jacobsen, 2006), a revised framework for urban migrant groups is presented. This framework considers access to ART as an additional and essential resource that enables poor urban, HIV-positive migrants to increase control over their lives, allowing a survivalist livelihood (at minimum) to be maintained. This framework shows that upholding individuals' right to access ART can impact positively on the ability of individuals to maintain an otherwise fragile, survivalist livelihood. Local authorities and communities will benefit from the contribution that international migrants can make, both socially and economically. In addition, this increases the likelihood of refugees and asylum seekers becoming self-sufficient in terms of the South African urban refugee policy.

The livelihoods framework presented will contribute to the development of a framework designed to guide local-level responses to migration in the context of the HIV epidemic.<sup>2</sup> The recommendations are intended for urban planners at the provincial and local levels, to help ensure that the rights to health and employment are upheld for all, according to the developmental mandate of South African local government.

### **Complex urban contexts**

Urban environments are characterised by a complex interplay of issues resulting from global trends in urbanisation. This paper focuses on urban contexts in developing countries; these are defined as presenting a set of developmental challenges to local governments, which includes: 1) high rates of migration from rural areas and across borders, including by those seeking refuge; 2) high HIV prevalence in urban areas, often highest within informal urban areas;

3) survivalist livelihoods located within the informal sector; and 4) increasing urban inequalities that impact on urban poor groups, defined as experiencing a range of urban 'deprivations' (Mitlin & Satterthwaite, 2004). In addition, developing-country urban contexts can be characterised by large numbers of residents living with "weak rights to the city" (Balbo & Marconi, 2005, p. 13). This manifests as challenges to realising their rights to access social services, employment, housing and security, which are variously outlined below.

### **Urbanisation and migration**

Urbanisation is associated with a high frequency of migration to urban hubs: this includes rural-to-urban economic migration, circular labour migration, and movement across borders by those seeking asylum (Garenne, 2006). This results in a range of interlinked developmental challenges that present multiple health and social needs, requiring intersectoral action from relevant local authorities. Understanding how to ensure and sustain the public health of urban populations is of increasing importance since over half of the world's population is now urban (UNFPA, 2007).

It is estimated that there are approximately 200 million international migrants, equating to roughly 3% of the world's population (The Global Commission on International Migration, 2005). Migration to urban areas puts increasing pressure on the ability of provincial and local governments to respond to the public health and social-service needs of urban populations. This pressure is felt particularly strongly within complex developing-country urban environments where additional challenges are presented to city authorities. These include magnified migration flows and high urban HIV prevalence, which together provide additional contextual challenges. Within developing-country contexts, where economic, social and health inequalities prevail, migration to urban centres is becoming a coping strategy of families and communities, intended to improve the living conditions of both the migrant and those who remain behind (Balbo & Marconi, 2005).

This paper considers migration as a persistent challenge to developing-countries' urban local governments, and as a social determinant of individuals' health. Social determinants of health are regarded as the underlying conditions that result in a range of health outcomes (Commission on the Social Determinants of Health, 2007). The healthcare system itself acts as a social determinant of health (Gilson, Doherty, Loewenson & Francis, 2007).

### **Health, HIV, and migration in a developing-country urban context**

Ensuring good health presents many challenges within complex urban contexts, particularly within developing countries (Harpham & Tanner, 1995; Harpham & Molyneux, 2001; Waelkens & Greindl, 2001; Galea & Vlahov, 2005). While assessing the relationship between migration and health is challenging (Banati, 2007), migration is increasingly recognised as a determinant of individuals' health, in turn requiring appropriate policy and programme responses (MacPherson & Gushulak, 2001; Anarfi, 2005). Within complex urban environments where migration persists, public

health and development are inextricably linked, therefore requiring integrated responses to achieve positive change (Harpham & Molyneux, 2001; World Health Organization, 2005). Such positive change relates to improving the health outcomes for migrant populations and ensuring that they have access to appropriate public health and social services. This includes access to ART where necessary.

HIV presents an additional health and development challenge to urban authorities in developing countries. Reader (2005, p. 218) reminds us that “although cities have been the economic, social and cultural powerhouses of human endeavour, they are a bad idea in biological terms.” This is particularly evident in sub-Saharan Africa, the region most affected by HIV globally (UNAIDS, 2007), and where urban areas are associated with approximately 1.7-times higher HIV prevalence compared to their rural counterparts (UNAIDS, 2006). HIV and the associated continuum of care needs — from prevention, to testing, to care, to the effective provision of treatment — is a central urban health concern that presents a range of developmental impacts. This requires an appropriate response — creative and multisectoral — that actively involves a range of government departments in a developmental way (Thomas, 2003).

While this paper focuses on access to treatment for HIV, it is important to consider the role that migration plays in determining individuals' health and vulnerability to HIV. The links between migration and HIV have been previously explored and it is clear that where mobility is prevalent there are “clear trends towards the spread of the disease” (Banati, 2007, p. 205). However, while provincial and local governments have previously been concerned that foreign migrants may bring HIV with them, it is increasingly recognised that migrants may be more vulnerable to acquiring HIV infection than are the local population (Anarfi, 2005). As such, it is important to consider the context in which migrants find themselves (Banati, 2007).

While there are two distinct processes, namely the vulnerability to infection and the possibility of transmitting HIV, a “double dynamic relationship” is formed between the process of migration and HIV risk (Anarfi, 2005, p. 100). Important here is the concept of “prevalence gaps,” described as “a differential in health risk between two locations or situations that may be crossed or bridged by travel” (MacPherson & Gushulak, 2001, p. 394). Migration can engage individuals in disparities in health and health determinants (MacPherson & Gushulak, 2001). Moving to a new location that has a different health-risk profile can present new influences and outcomes concerning an individual's health (Anarfi, 2005). Importantly, this may involve differences in access to and quality of healthcare services (MacPherson & Gushulak, 2001). In the context of HIV, migrants are at greatest risk of infection (and transmission) once they have arrived in their host location as it is at this time that an individual's behaviour may change, but importantly they may have moved from an area of low HIV prevalence to an area of high prevalence (Anarfi, 2005). While the common misconception that migrants are ‘disease carriers’ prevails, studies are emerging that provide evidence to the contrary (e.g. see Spiegel, Bennedsen, Claass, Bruns, Patterson, Yiweza & Shilperoord, 2007).

This paper argues that HIV presents a parallel developmental challenge to local government as HIV impacts on individuals, households and communities (both migrant and host) in multiple ways, beyond narrow health considerations. Consequently, the HIV epidemic requires multisectoral responses that integrate programming across the social, welfare, economic, development and health departments of local, and where appropriate, provincial governments.

### ***The urban poor***

The vulnerability of groups of urban poor is well documented (Harpham & Molyneux, 2001). This paper considers urban-poor groups as those that fall within Mitlin & Satterwaite's (2004, p. 11) definition of urban poverty: a concept covering a multitude of interlinked “deprivations.” This broader definition of poverty allows for the conceptualisation of approaches that tackle the *needs* of poor people, and highlights the complex interplay of factors, including health, environment and development, present within urban environments. Additionally, this definition recognises the need to move away from a purely income-related measure of poverty by acknowledging that levels of income, or consumption, do not reflect levels of access to necessary services, security, or good health. Importantly, this definition of urban poverty generates many possible entry points — encompassing both livelihood strategies and HIV coping strategies — for tackling poverty and allowing for innovative, integrated programme and policy responses at the local level. In the context of developing-country urban environments, the effects of HIV arguably contribute an additional deprivation for urban-poor groups. Hence, many migrants to urban areas, including most international migrants (Balbo & Marconi, 2005), add to urban-poor groups, presenting specific challenges to local governments, which require appropriate policy and programme responses.

### ***The informal economy and a survivalist livelihood in an urban context***

The livelihoods of the poor are determined by the context in which they are located, and the opportunities and constraints that this context provides. The context (economic, environmental, social, political) determines the assets that individuals are able to access, how they use them, and therefore their (in)ability to obtain a secure livelihood (Meikle, 2002). Urban livelihoods are particularly distinct as a result of the specific complexities presented within a complex urban context (Meikle, 2002). Individuals working within the informal economy within South African cities are considered among the most marginalised: dependent on ‘survivalist’ activities, they are mostly African, female and young, and therefore susceptible to HIV infection (Vass, 2003).

There is growth globally in the numbers of people working within the informal economy. International statistics estimate informal employment to comprise one-half to three-quarters of non-agricultural employment in developing countries; in sub-Saharan Africa, this figure is estimated at 72% (International Labor Organization [ILO], 2002, in Devey, Skinner & Valodia, 2006). While there are problems with available data, it is accepted that in South Africa the informal economy has created employment mostly in the

retail and wholesale trades and has grown between 1997 and 2003, whereas employment in the formal economy has shown limited growth (Devey *et al.*, 2006).

Various debates exist that critique the use of the term 'informal sector' or 'informal economy'; nevertheless, the (dis)connections between the formal and informal sectors, and use of the 'second-economy' concept, suggests that a dual economy is present within South Africa (for an overview of current debates, see Devey *et al.*, 2006). These debates are beyond the scope of this paper; therefore, the term informal economy is used to relate to the survivalist livelihoods often found among urban refugees, asylum seekers and undocumented migrants.

### **The case of South Africa**

South Africa presents a relevant example within which to explore and understand the persistent developing-country urban challenge of migration in the context of HIV. In South Africa, adult HIV prevalence is typically highest in urban areas (UNAIDS, 2006), estimated at 9% in formal urban areas, rising to 18% in informal urban areas (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana *et al.*, 2005). Within South Africa, and the southern African region, urban pressure will continue to increase as migration persists as a result of continued economic migration, and, increasingly, with the arrival of refugees and asylum seekers from across the continent (Landau, 2006a). It is therefore essential that local government in South Africa is able to plan for and respond to the persistent challenge accompanying a high degree of migration, and especially to consider the implications to urban health and livelihoods within the context of HIV. This includes ensuring that the right to access ART is upheld for all who need it in South Africa.

The South African context stands out because South African local government has a developmental mandate, described as a "local government committed to working with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives" (RSA, 1998b, p. 23). Although challenges to the realisation of this mandate have been reported (see Harrison, 2006; Nel & John, 2006), the developmental mandate provides a useful framework within which to describe the challenges presented, and to provide recommendations for action with the intention of ensuring and maintaining good public health of the population.

### **The City of Johannesburg and the context of HIV**

This paper presents findings from a case study of the City of Johannesburg, which examines HIV in a complex developing-country urban context with high frequencies of in-migration and survivalist livelihoods.

Located in the densely populated Gauteng Province, Johannesburg is South Africa's largest city and economic centre. With a population estimated at nearly 3.9 million, the city has grown by 20.5% since 2001, with an average growth rate of 4.16% per year (City of Johannesburg, 2008). It is estimated that 6.2% of the city's total population are international migrants (Balbo & Marconi, 2005). The city's population is expected to reach 4.2 million by

2010, and increase by another one million by 2015 (City of Johannesburg, 2008).

As discussed previously, HIV requires a developmental response at the local government level, yet HIV has "major implications for many areas of urban governance" (Crush, 2005, p. 114). "HIV/AIDS is not only a health problem. Its detrimental consequences reverberate across the social life of Johannesburg and thus across policy areas" (Thomas, 2003, p. 195). The developmental mandate of the Johannesburg Metropole "urges local government to focus on realising developmental outcomes, such as...the creation of liveable, integrated cities...and the promotion of local economic development..." (RSA, 1998b, p. 8). Given that migration can be a determinant of health (MacPherson & Gushulak, 2001; Anarfi 2005), which is arguably magnified in the context of an HIV epidemic, developmental city policies must incorporate migrant groups within all HIV prevention, care, and treatment programmes as otherwise afforded to citizens.

### **Migration to Johannesburg**

Johannesburg is a relatively young city; it grew rapidly in the late 19th century as a result of the rapid arrival of labourers to work on the large gold reef upon which the city was to evolve. As a 'city of migrants' (Crush, 2005), Johannesburg has always been a cosmopolitan centre, home to a heterogeneous population of migrants, many of whom come from within South Africa (internal migrants) (Beavon, 2004). Rural-to-urban movement has become today's rite of passage for many young rural South African men and women. In addition, the end of apartheid opened up South Africa's cities to diverse African migrants, including individuals seeking asylum and refuge (Crush, 2005; Landau, 2005b and 2006a).

Today the city struggles to meet the multiple and growing needs of a constant stream of new arrivals, and this presents a range of challenges to urban governance (Crush, 2005). The number of young adults arriving in the city far exceeds the demand for labour, an imbalance created by the decline in the manufacturing and mining industries (Beavon, 2004). High levels of unemployment aggravate the inequalities experienced within the city, and the number of those without access to a secure livelihood continues to grow (Beall, Crankshaw & Parnell, 2002). Although migrants may typically struggle to access a secure, formal urban livelihood, it is important to recognise that informal livelihood opportunities in urban areas exceed employment opportunities in rural areas in South Africa (see also Cornwell & Inder, 2004).

### **Urban refugees and immigration policy**

Migrants constitute an important group in developing-country urban environments; Johannesburg attracts rural-to-urban and cross-border migrants, including refugees and asylum seekers. The importance of urban informal settlements for migrant communities is recognised (Banati, 2007). However, this paper focuses on the dense urban environment of inner-city Johannesburg. While rigorous data on such 'hidden' migrant populations is scarce (Jacobsen & Landau, 2003; Banati, 2007; Vigneswaran, 2007), particularly within

urban areas (Jacobsen, 2006), a 2002 survey found that almost a quarter of Johannesburg's inner-city residents were born outside South Africa (Leggett, 2003). The survey also highlighted the internal movements of South African citizens: 68% of inner-city residents (three-quarters of whom were South African) had moved to their household in the last five years (Landau, 2006b). More recent survey data suggests that in certain inner-city neighbourhoods, over half of the residents are non-nationals (Landau, 2006b).

In accordance with the South African Constitution's commitment to human rights and dignity, South Africa has a refugee policy that facilitates individuals' freedom and protection through enabling the temporary integration of refugees into local communities (Landau, 2006a). Unlike other countries in the region, no refugee camps exist in South Africa<sup>3</sup> and many refugees and asylum seekers find themselves in complex urban environments such as Johannesburg. These individuals are assured the right to access existing welfare services, such as healthcare. Displaced persons within South African cities are expected to become self-sufficient by earning a living and temporarily integrating within the host community (Landau, 2006a).

A restrictive immigration policy (RSA, 2002 and 2004) makes it difficult for low- and moderately skilled labour migrants to legalise their stay in South Africa, sometimes encouraging such individuals to make use of the asylum process as a 'backdoor' to legalising their stay in South Africa (Landau, 2006a; Crush & Dodson, 2007). It is possible for highly skilled workers to apply for permanent residence, but others are excluded, often criminalised, and meanwhile unable to access social services, while they risk detention and deportation (Landau, 2005a).

#### **Urban-poor groups: refugees and asylum seekers**

While the policy set out by South Africa's immigration acts is progressive, and indeed various acts<sup>4</sup> exist to afford many rights to refugees, implementation remains challenging (Bailey, 2004; Landau, 2006a). Challenges to local government occur within an unequal and complex environment that is common to developing-country urban environments such as Johannesburg (Jacobsen, 2006). Many (but not all) refugees and asylum seekers in urban areas are a "subset of the national urban poor" (Jacobsen, 2006, p. 276), who confront the same structural problems that the host population experiences in relation to urban poverty (De Vriese, 2006; Jacobsen, 2006). It is argued that refugees and asylum seekers within Johannesburg constitute a good example of a vulnerable urban-poor group; despite protective policies, refugees and asylum seekers in the city regularly experience limited access to required documentation, health and social services, and economic, social and physical opportunities (Bailey, 2004; Pursell, 2004; Crush, 2005; Jacobsen, 2006; Landau, 2006a, 2006b and 2007; CoRMSA, 2007).

Landau (2006a) describes the shortcomings in South Africa's policy for urban refugees, highlighting that while effective protective policies exist, government institutions are often unable to convert legal entitlements into effective protection, which results in their failure to meet both domestic and international obligations. The shortcomings

include: institutional failures, the denial of social services, and abuse from the police (Landau, 2006a), which manifest as ignorance, xenophobia and legal discrimination (Landau, 2007). The Department of Home Affairs is responsible for issuing documentation to refugees and asylum seekers, while the inefficiency of the department has been previously reported (Landau, 2006a). While "identity documents cannot prevent discrimination or ensure social inclusion" (Landau, 2007, p. 65), and provision of documentation is not the solution (Bailey, 2004; Jacobsen, 2006; Landau, 2006a), a lack thereof impacts on an individual's ability to claim their rights.

Given the shortcomings in implementing the urban refugee policy (Landau, 2006a), urban environments present a range of challenges to refugees' protection and livelihoods, compared to those who are housed in camps (Jacobsen, 2006), although camps prevent foreign migrants from integrating politically, economically and socially (Landau, 2007). However, if local authorities enabled an environment that includes refugees and asylum seekers, and upheld their rights, it would increase the likelihood of this group becoming economic or social assets to the city they reside in (Jacobsen, 2006). While international migrants can bring social and economic benefits to a city, they are rarely considered within the political agenda (Balbo & Marconi, 2005). Crush (2005, p. 144) stated: "Migrants must be seen primarily as an opportunity; not an intrusion." There is an urgent need to address this topic given the current episodes of xenophobic violence against predominantly African migrants within South Africa (Jacobs, 2008).

#### **Livelihoods among urban international migrants**

It is imperative to understand the social, economic and policy context within which refugees and asylum seekers must pursue a livelihood (Jacobsen, 2006); while they face difficulties in accessing employment (Landau, 2007) and are often compelled to work informally because of their inability to access necessary documentation (Crush, 2005; Landau, 2006a). For this reason, a livelihoods framework has been used previously to understand the experiences of urban refugees (De Vriese, 2006; Jacobsen, 2006). The benefits of such a framework stem from three key components, namely addressing: 1) the context of vulnerability (legal status); 2) the assets and strategies employed (social capital); and 3) the outcomes experienced (consequences to the host) (Jacobsen, 2006). In addition, a livelihoods-framework approach has the advantage of being cross-sectional by way of considering "the totality of economic, political, social and cultural factors affecting people's lives and livelihoods" (Collinson, 2003, p. 4).

Jacobsen (2006) makes use of the *vulnerability context* to refer to the legal status of refugees within an urban area. Refugee policy should support the creation of sustainable livelihoods, but problems occur when state obligations are only partially fulfilled. Jacobsen (2006) uses *assets* to represent social capital, referring to individuals' reliance on the support of other foreigners already in an urban area, and incorporating material and emotional support and connections to employment and financial networks.

The consequences to the host society are considered as *outcomes* (Jacobsen, 2006). Jacobsen (2006) argues that refugees can benefit the host community only when they are allowed to pursue their legislated right to work freely and to integrate. For instance, urban refugees may find ways to support themselves through the informal economy, therefore contributing to the host city's economy (Jacobsen, 2006). It is argued in this paper that such a livelihoods framework should be expanded to include all international migrants to an urban area.

I consider international migrants, who rely on a survivalist livelihood in the context of HIV, and particularly those in need of treatment, as one of the most socially disadvantaged groups in South African society today. This group falls within Mitlin & Satterthwaite's (2004) definition of poverty, which specifies key deprivations as unstable incomes and difficulties in accessing services.

## Methods

Recognising the difficulty of measuring the extent of migration and migrant communities (see Jacobsen & Landau, 2003), the data were triangulated, combining both qualitative and quantitative methods. The data were acquired from two surveys and a range of semi-structured interviews.

The African Cities Survey, undertaken in 2003 and again in 2006 by the Forced Migration Studies Programme (FMSP) at the University of the Witwatersrand, South Africa, and partner institutes,<sup>5</sup> was a survey of self-settled migrants in Johannesburg, Maputo, Lubumbashi and Nairobi (see Jacobsen & Landau, 2003; Landau, 2004 and 2006a; Vigneswaran, 2007). The present study uses responses to the 2006 African Cities Survey to illuminate the livelihood strategies of international migrants to Johannesburg; that portion of the survey included a random sample of migrants (mostly individuals from the Democratic Republic of the Congo, Mozambique and Somalia, as well as South Africans) living in the inner city of Johannesburg, wherein 847 respondents participated (656 international migrants and 191 South Africans). The overall design of the African Cities Survey was reported by Jacobsen & Landau (2003) and Vigneswaran (2007).

Second, data concerning urban migrants' access to ART were acquired from a cross-sectional, comparative study of three categories of migrants (i.e. refugees and asylum seekers; migrants with visitor permits; and undocumented migrants) and a control group of South Africans, undertaken by the author in 2007. The research was conducted in inner-city Johannesburg at four sites providing ART (two governmental and two non-governmental); the sites were purposively selected from areas known to have high concentrations of migrants (see Jacobsen & Landau, 2003). The ART access study comprised: 1) a survey questionnaire administered to randomly selected citizen and non-citizen ART clients at each of the four sites, whereby 449 respondents were interviewed (93 non-citizens and 356 South Africans); 2) 34 semi-structured key informant interviews with healthcare providers who worked within ART services at the

sites; and 3) a focus group discussion with eight HIV counsellors, who were themselves refugees.

Third, to explore possible links between access to ART and a survivalist livelihood, 19 semi-structured interviews were undertaken with cross-border migrants living in Johannesburg (including refugees, asylum seekers, migrants with visitor permits and undocumented migrants), and 4 semi-structured interviews were conducted with South African citizens who had migrated to Johannesburg. Individuals were eligible to be interviewed if they were aged 18 years or over; were currently working in the informal sector; had been receiving ART for a minimum of six months; and were currently well. Accordingly, individuals at a non-governmental inner-city ART site (known to treat cross-border migrants) were randomly selected and invited to participate.

These interviews took place in March and April 2008. The survey questionnaire and the semi-structured interviews were conducted by fieldworkers conversant in a range of African languages, while the interviews and focus group discussion with the healthcare providers working with ART services were conducted in English by the author.

Ethical approval was obtained from the University of the Witwatersrand Medical Ethics Research Committee (protocols M070612 and M071125). Information sheets were given to all the participants and their informed consent was obtained. Data from the 2006 African Cities Survey and the 2007 survey questionnaire were entered into Excel and imported and analysed using SPSS 10.1. Bivariate analysis used chi-square statistics, and descriptive statistics were used for the categorical data and measures of central tendency for the continuous data. The qualitative interviews were digitally recorded and then transcribed and translated as necessary; the transcripts were analysed using thematic content analysis (see Miles & Huberman, 1994).

## Results and discussion

This section presents and discusses the preliminary findings from the data gathered in the 2006 African Cities Survey ( $n = 847$ ), the 2007 ART access survey questionnaire ( $n = 449$ ), and the various semi-structured interviews conducted in 2008. A revised livelihoods framework for urban migrants is also presented.

### *The 2006 African Cities Survey*

#### *Reasons for migration*

Of the 656 international migrants responding to the 2006 African Cities Survey in Johannesburg, the most common reasons given for coming to Johannesburg were: economic opportunity (37%); to avoid war, violence or conflict (19%); and to find political freedom (13%). While health or health-care-seeking was not given as a reason for moving to the city, access to improved economic opportunity was stated as important. Sixty-three percent of the respondents identified themselves as refugees or asylum seekers, but less than half reported having officially received refugee status at the time of the survey (which infers challenges in accessing documentation as described elsewhere) (Jacobsen, 2006; Landau, 2006a and 2007).

### *Livelihood strategies*

Just over one-quarter (28%) of the international migrant survey respondents ( $n = 656$ ) reported being currently unemployed, 31% stated they were working full-time, and 21% said they did casual or temporary work or were self-employed. The remainder (20%) identified themselves as a homemaker, student or voluntary worker. Those who were currently working stated a range of income-generating activities. Just over one-quarter identified themselves as working within a professional vocation (20%) or within the media (6%). Additionally, 33% of the respondents reported they had employed and paid someone else since arriving in Johannesburg (this included both South Africans and other international migrants), thereby demonstrating the contribution that international migrants can make locally: creating jobs and employment.

The importance of the informal economy to the international migrants in Johannesburg was clear: the majority of respondents who reported that they were working identified themselves as working informally. The informal economy is heterogeneous in South Africa (Devey *et al.*, 2006): different types of economic activity (e.g. trading or manufacturing), employment relations (self-employed, paid or unpaid), and livelihood activities (from survivalist to successful small enterprises) are present. Reported activities in the 2006 African Cities Survey included working as a car guard, construction worker, domestic worker, factory worker, street hawker, shoe repairer, or restaurant waitron.

### *Remittances*

Almost half the 2006 survey respondents ( $n = 656$  international migrants) said they supported others by sending money out of Johannesburg. The majority supported a parent (78%), 34% supported siblings, and 21% supported close relatives. Large proportions sent away money monthly (41%) or several times a year (21%), and 30% reported sending money for special needs. This characteristic transfer of funds earned by migrants was also noted in the interviews conducted for the ART study.

The insecurity of an urban livelihood is reflected through the one-quarter of 2006 survey respondents who indicated that they received money from outside Johannesburg: from close relatives (38%), siblings (32%), parents (30%), or friends (13%). These respondents mostly received money monthly, or else for special needs.

While the livelihood strategies employed by most respondents were essentially survivalist and located in the informal economy, these individuals were often financially responsible for a range of family members based outside Johannesburg, primarily in their country of origin. Thus, participation in the urban informal economy was significant as it could provide a livelihood to the migrant and a range of dependants.

### *Interviews with migrant ART clients*

All of the interviews conducted with HIV-positive migrant ART clients who were currently working in the informal economy in Johannesburg ( $n = 19$ ) indicated the importance that access to ART has had on their ability to either maintain (if treatment was initiated before an individual was sick) or

regain (if treatment began after an episode of sickness) their survivalist livelihood. Individuals reported their involvement in the informal economy as including: selling second-hand clothes and household goods; making and selling lunches to contract workers in the inner city; working in a hair salon; training as a tailor; panel beating and spray painting; working in a scrap yard; and informal employment as waitrons in restaurants and as security guards. In addition, 'piece jobs'<sup>6</sup> that provided an informal livelihood including painting, construction work, gardening and plumbing.

Access to ART clearly acted as an essential resource to individuals' ability to support themselves and their dependants. For example, a Zimbabwean female sent groceries and cash back to her children and mother while she worked informally for a catering business. HIV-related illness had forced her to stop work for four months; ART, however, restored her health and she had resumed her livelihood and her ability to help support her dependants in Zimbabwe. A Zambian female migrant was involved in buying fish in Zambia, which she then re-sold in South Africa. She became very sick before testing for HIV and was unable to walk, forcing her to abandon her livelihood. However, once on ART, she could resume her informal trade and start sending groceries to her brother, sister and children in Zambia. A Zimbabwean male had come to Johannesburg for work in 1998. He became very sick in 2003 and sold his belongings to raise funds so that he could travel back to Zimbabwe in 2004 where he was cared for by a family member. After initiating ART in Zimbabwe in 2006, he regained strength and returned to Johannesburg in 2007 to work informally as a panel beater. Although his income was unreliable, he felt that the opportunity for earning a livelihood was better in South Africa than in Zimbabwe. He sent money home to his children when he was able.

Thus, the importance of starting ART before illness occurs was reflected in the participants' responses. Programmes must encourage early HIV testing among groups of migrants as well as citizens. For example, a Zimbabwean female migrant tested for HIV before she was sick; through monitoring her CD4 cell count, she started ART early on and did not fall sick. This enabled her to maintain her informal livelihood as a waitress, and her (uninterrupted) ability to continue to send groceries to her dependants who remained in Zimbabwe.

Early HIV testing relates to two key issues: 1) allowing an individual to maintain health and prevent death, and 2) enabling an individual to maintain health in order to maintain (at least) a survivalist livelihood. All of the individuals interviewed in early 2008 were accessing ART within the non-governmental sector; their comments support observations made by Pursell (2004) and Landau (2006a) that access to the public (government-run) health system in Johannesburg presents many challenges for non-citizens. A key issue is access to documentation: none of the individual migrant respondents ( $n = 19$ ) in the 2008 interviews had received refugee status; the majority had asylum-seeker permits or lacked documentation, and the remainder used visitors' permits that they periodically renewed at the border. Likewise, almost half of the non-citizen ART clients in the ART study (2007 survey) were without documentation,



and almost all of these individuals accessed ART from the non-government sector.

### **The ART access study**

#### *HIV testing and access to ART*

The majority of respondents to the survey questionnaire used in the 2007 ART access study said they had tested for HIV when they were already sick: 64% of non-citizens and 55% of South Africans (chi-squared;  $p = 0.122$ ). This is a worrying finding: individuals tended to test only when they became sick and very few seemed to test due to their awareness of HIV (just 11% of the South Africans and 9% of the non-citizens). This implies that campaigns encouraging individuals to know their status have not been effective, neither for South Africans or migrants in this location.

Eighteen percent of the non-citizen respondents had started ART at the site where they had tested. Sixteen percent of non-citizens had been referred to an ART site by a family member or a friend, and 12% had been referred by a government-run clinic. This suggests that non-citizens access non-government HIV-related services because government-run ART roll-out sites refer them and because migrant networks facilitate this. Non-citizen ART clients seem likely to be referred out of the public sector, as individuals without South African identity documents seem to struggle to access services beyond HIV-testing in the public sector.

#### *Challenges to healthcare access: time and cost*

Many clients participating in the ART access study reported a lack of money for transportation as a barrier to collecting treatment, and also that it was problematic to take time away from their livelihood (especially if they were employed by someone else). This was also mentioned in the interviews with healthcare providers, where ART clients' employers were referred to as barriers to accessing treatment. The interviews with migrant clients in the ART study did not set out to assess the cost of access to treatment (considering both financial and time costs). However, their comments clearly illustrated that HIV-related sickness prior to initiating ART results in individuals having to either stop their livelihood (if working on their own) or having to handover their livelihood strategy to others (as prolonged absence from their livelihood activities meant they could not continue). This resulted in individuals becoming reliant on others, no longer being able to support their dependants, or employing someone else to run their informal business on their behalf until they sufficiently recovered.

#### **ART access in the public sector: the challenge of documentation**

Despite a memo from the Department of Health<sup>7</sup> (2006) stating that individuals do not require a South African identity document in order to access ART, the findings of the ART study show that non-citizens are essentially unable to access treatment in the public sector in South Africa. Some ART roll-out sites continue to insist upon the presentation of a South African identity booklet before treatment can commence. Importantly, non-citizens are frequently referred out of the public sector at the time they test for HIV. Hence,

most non-citizens answering the 2007 survey questionnaire (78%,  $n = 71$ ) reported they were accessing ART within the non-governmental sector where documentation is not a prerequisite for treatment. The non-governmental ART sites provided services through churches, with funding obtained from international donors. Administrative, nursing and counselling staff were employed full-time, while the clinicians were mostly working between the public (government-run) and non-governmental sectors, typically offering one or two non-governmental-site visits per week.

Only 22% of all non-citizens interviewed (15.4% at government site A and 6.6% at government site B) were successfully accessing ART at government sites. The difference in these proportions at the two public-sector sites can be explained by differences in institutional-level policy; this finding is problematic as it reflects a situation wherein institutions are implementing their own policies that go against existing legislation.

Denying migrants access to healthcare presents both short-term and long-term consequences. In the short term, there is physical risk to the individual and impacts are experienced by their dependants; in the long term, there are setbacks to public health. Infectious diseases do not discriminate (Landau, 2007); migrants share city space with the host population, and therefore share health problems. In the ART study, tuberculosis (TB) revealed itself as a large problem for both South African citizens and international migrants; respondents' stated that TB infection was a main reason for deciding to test for HIV.

#### **Non-citizen ART clients**

The ART access survey found that clients' mean age among the four sites was 35 years (range, age 20 to 62 years). The majority of respondents were in the age group 31–40-year-old, and 50% were under age 34. There were no significant differences in the age distribution of the non-citizen group compared to the South African population ( $t$ -test;  $p = 0.134$ ). This pattern was likewise found in the 2006 African Cities Survey data and was supported in the semi-structured interviews (where participants' mean age was 36 years).

The 2006 African Cities Survey data reflected patterns of predominantly male migration to Johannesburg (63% males and 37% females). However, the gender distribution of migrant clients observed in the ART study reflected both the gendered nature of the disease and gendered patterns in health-seeking behaviour, particular in terms of ART (see Wilson & Fariall, 2005): roughly one-third of those respondents were males and two-thirds were females, and the proportions were similar for both citizens and non-citizens, with no difference observed in gender distribution between those two groups (chi-squared;  $p = 1.0$ ). Almost half (45%) of the non-citizens reported living in an inner-city neighbourhood (Yeoville, 23%; Hillbrow, 14%; or Berea, 9%) compared to 22% of the citizen respondents. If the central business district (CBD) is included, the percentages increase to almost 60% of the migrant non-citizens ART clients residing in the inner city, compared to 25% of citizen clients. This finding supports previous research that identified high concentrations of non-citizen residents in these Johannesburg inner-city neighbourhoods (Jacobsen

& Landau, 2003). In addition, the 2007 ART-access survey data indicated that 75% of new arrivals (those who reported they had arrived in South Africa within the last 12 months) were residing within inner-city areas (i.e. Yeoville, 30%; Hillbrow, 20%; Berea, 5%; and the CBD, 20%), supporting the idea that these dense inner-city areas are entry points for recent arrivals to Johannesburg.

### ***The demand for identity booklets***

Healthcare providers at the four ART sites visited expressed concern relating to the demand for clients to provide a South African identity booklet. Some stated that this insistence could motivate individuals to obtain fraudulent documents. Staff were particularly concerned that this would result in patients being dishonest with their healthcare providers, which would result in greater problems in relation to adherence counselling and requests for additional medication (for example, if one planned to visit his/her home country for an extended period), ultimately impacting upon the value of treatment.

### ***Health-related migration***

The majority of non-citizen respondents (76%) in the ART access study had first tested for HIV in South Africa, and most (80%) had learned of their positive status in South Africa. This indicates that migrants are often only testing and discovering their status once they are in the country. Yet the respondents often indicated that their health or knowledge of their HIV status was not a reason for migrating to South Africa. This generalisation was supported by responses to the 2006 survey, where individuals largely indicated they had come to Johannesburg for reasons other than health. This was similarly revealed in the semi-structured interviews, where only one of 23 migrants said she had come to Johannesburg for ART. In this one case, a female from Zimbabwe was brought to Johannesburg by her sons (who already resided in Johannesburg) because they felt she would receive better treatment there.

### ***Migrants' adherence to ART***

This study found no significant difference between the numbers of non-citizen and citizen ART clients who reported that they sometimes failed to collect treatment ( $p = 0.675$ ) or did not adhere to treatment ( $p = 0.404$ ), lending support to the principle of providing ART to all individuals within South Africa.

### ***A dual healthcare system***

Non-citizens are commonly referred out of the public health sector and directly into the NGO sector in order to access ART, resulting in a dual healthcare system (public and non-governmental), which provides ART through separate routes to different groups of people. This raises concerns in terms of logistical issues and the responsibility of the public health sector alternately being met by NGO providers.

### ***A revised livelihoods framework for urban migrants***

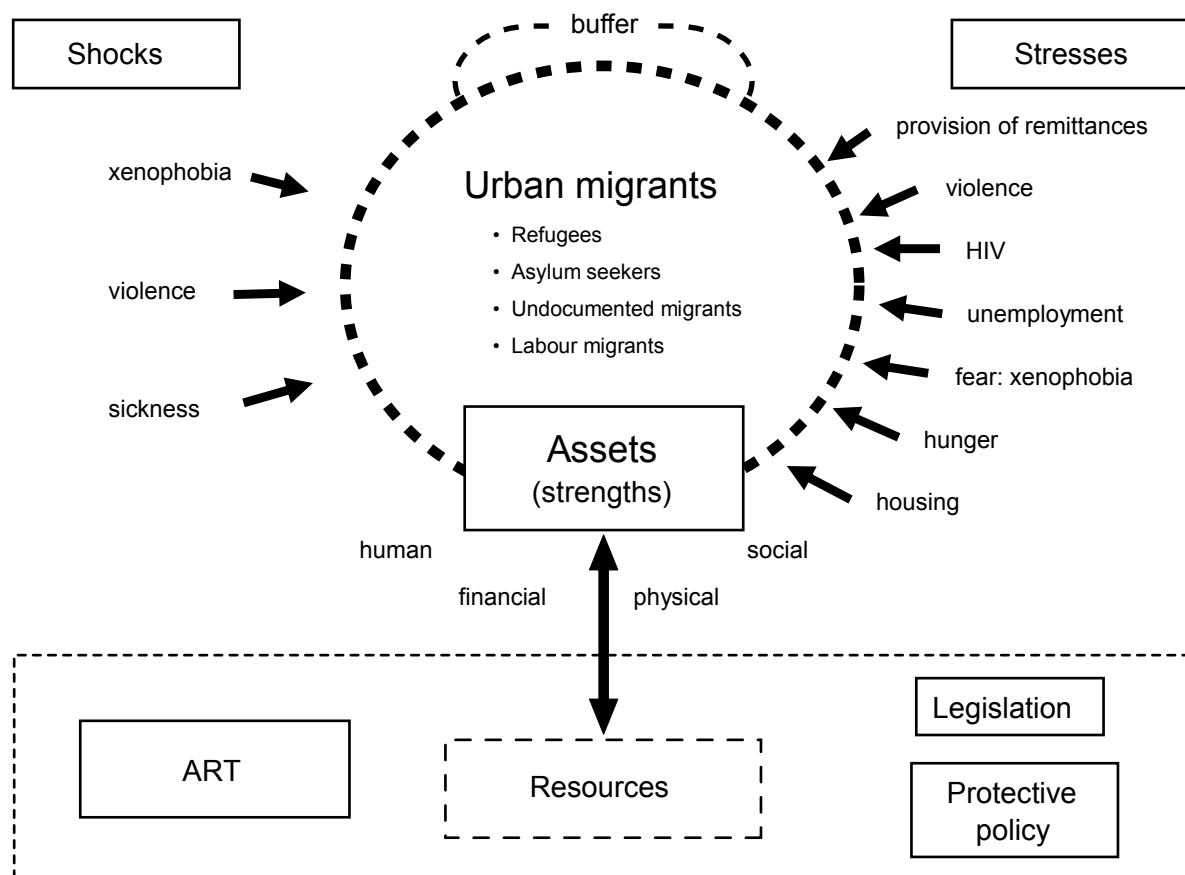
Previous work on the livelihoods of urban refugees has shown that a livelihoods analysis is useful for understanding

the strategies employed by urban refugees (Jacobsen, 2006). I present a revised livelihoods framework concerning all urban migrants (including refugees, asylum seekers, labour migrants and undocumented migrants), which builds on previous work by Jacobsen (2006) as well as the sustainable livelihoods literature (e.g. Chambers & Conway, 1992; Carney, 1999 and 2002; Meikle, Ramasut & Walker, 2001; Meikle, 2002; Rakodi, 2002).

“A livelihood is sustainable when it can cope with and recover from stresses and shocks and manage to enhance its capabilities and assets both now and in the future...” (Chambers & Conway, 1992, pp. 7–8). Importantly, when considering recommendations for intervention, a sustainable livelihoods approach enables an “intersectoral, holistic understanding of people’s lives whereby sectors such as health, education, employment and environment are seen as being intrinsically linked” (Harpham & Grant, 2002, p. 165). Such an approach can benefit international migrants in the context of the multiple challenges they face in complex developing-country urban environments. This is achieved through finding entry points that will enable interventions that can assist individuals to obtain additional assets (strengths) and build on these in order to access and obtain additional resources. By continuously developing and locating these assets and resources, an individual can become better able to cope with the shocks and stresses they may encounter on a daily basis. Therefore, through an urban livelihoods approach, it is argued that an increase in an individual’s level of control will lead to an increase in assets and therefore access to resources. This will in turn improve not only livelihood options, but may improve an individual’s coping skills when dealing with the long-term stresses of HIV (Barnett, 2006), as well as improving other public health outcomes.

Figure 1 diagrams a revised sustainable livelihoods framework concerning urban migrants. Here, the relationship between assets and resources is centrally placed to benefit the buffer that individuals can create to protect themselves from the shocks and stresses of a developing-country urban environment. The buffer consists of the assets (and ultimately resources) that an individual, household, or community is able to acquire. For example, access to a secure house, employment, social networks, and secure public resources such as healthcare and documentation, would strengthen the buffer. Shocks are acute events, such as specific episodes of violence or illness; stresses are chronic, longer-lasting situations, which include the pressure to provide for others (including the sending of remittances), hunger, the fear of violence (such as related to xenophobia), or unemployment. HIV is considered a stress in as much as it is a long-wave event (Barnett, 2006). The presence of HIV within an urban environment presents a range of stresses to city residents; if an individual is HIV-positive, the living environment can impact negatively on an individual’s health and access to treatment or counselling and the related continuum of care that are required.

Building on Jacobsen’s (2006) work, assets are considered here to be more than social capital and more than access to financial networks: assets are the bridge used to access available resources that can strengthen an



**Figure 1:** Schematic of a sustainable livelihoods framework concerning urban migrants

individual's buffer, thereby increasing coping capacity. Assets are essential to safeguard an individual, household, or community from stresses and shocks. Assets may be human (the labour resource available), financial (access to a bank account or a grant, thus providing different livelihood options), physical (a safe and clean living environment), or social (social networks and relationships of trust and reciprocity) (see also Rakodi, 2002).

In the context of urban South Africa, making these types of essential resources available to urban migrants means ensuring that protective policies and legislation are implemented so that individuals are able to access those resources to which they have a right, particularly healthcare. Access to ART within a complex developing-country urban context such as Johannesburg should be more than just a legally enshrined right. It is an essential resource required to protect and sustain a survivalist livelihood. Through the availability of this resource, the often insecure livelihoods of HIV-positive international migrants (and migrant citizens) can be sustained or improved, in part by increasing individuals' ability to cope with the shocks and stresses present in a complex urban environment. In turn, individuals may contribute to the urban community and become self-sufficient as intended by South Africa's urban refugee policy.

## Conclusions and recommendations

South Africa has a progressive urban refugee policy; consequently, the rights to which individuals are entitled must be upheld. While the challenges to realising the rights of migrants and refugees are numerous, the resilience often displayed by urban refugees and asylum seekers indicates a need to move towards initiatives that enable the urban poor to better manage their situations. Likewise, it is important to understand the livelihood strategies regularly employed by migrants, including refugees and asylum seekers (De Vriese, 2006). Should they be able to access a secure livelihood, international migrants could vitally contribute to the cities in which they settle. In this regard, it is important to remember constraints relating to the Immigration Act and the difficulties experienced by lower-skilled workers who want to legalise their stay in South Africa.

In the context of HIV, as presented in one urban area of South Africa, it is essential that access to the continuum of HIV-related services, including ART, is facilitated to enable individuals to sustain an otherwise fragile livelihood; this right to healthcare is as important to international migrants as it is to citizens. Local government is responsible for providing appropriate HIV testing and referral systems, while provincial government remains responsible for ART

provision. While international migrants are able to access HIV testing and counselling within the public health system (as shown in the ART study) it is essential that the right to access ART is also upheld for *all* who need it in South Africa, regardless of individuals' documentation status. Access to ART, particularly early access before illness, has been shown to facilitate livelihood strategies, enabling individuals to support themselves and others. This requires the cooperation of both local and provincial government.

HIV is an important urban public health issue; ensuring free ART for all who need it will have public health benefits for both citizens and migrants. The proportion of non-citizens within South Africa is relatively small, but significant. Ensuring that individuals are able to access treatment early on will ultimately lessen the burden on the public health system as well as the burden within communities where households often care for the sick. Early-HIV-testing campaigns are required for all, but a focused intervention is required for migrant groups.

### **Recommendations for ensuring that migrants' rights are upheld**

This paper presents data that show the positive impact of access to ART for international migrants who make use of a survivalist livelihood. It is essential that access to ART is upheld for all who need it within South Africa in order to enable livelihoods to be maintained or improved.

While refugees and asylum seekers "constitute an even lower political priority for host governments and local authorities" (Jacobsen, 2006, p. 279), protective policies and guidelines do exist within South Africa to ensure access to healthcare for all, including international migrants. It is essential that these policies are uniformly implemented across the public sector. Appropriate training within the public healthcare sector (especially among institutional managers) relating to the rights of all international migrants, including refugees and asylum seekers, to access ART is urgently required. Local government authorities should urgently address this and strive to work with provincial authorities responsible for effective provision of ART. Training workshops and continuing professional development sessions could be utilised. It is recommended that local and provincial health departments audit institutional-level policy on international migrants and devise mechanisms to ensure that institutional-level policies are in line with national-level directives, policies and values. Local and provincial health departments must investigate and appropriately discipline public healthcare officials at all levels, including institutional managers, who contravene official policy.

The national Department of Health, in conjunction with provincial and relevant municipal authorities, are advised to fund and disseminate values-clarification training for healthcare workers and institutional managers concerning the rights of migrants to public healthcare services. The provincial health departments should work closely with a range of provincial and municipal government departments and groups, such as: the Department of Home Affairs, the South African Police Service, the Metro Police, the Department of Justice and Constitutional Development,

and the Department of Social Development and Welfare. This will assist in addressing the range of interlinked needs and rights of international migrants. Provincial health departments should establish a 'Migrant Helpdesk' in all districts, which can focus on providing assistance, advice and monitoring of migrants' access to public healthcare. It is recommended that the province liaises with and draws on lessons learnt from the City of Johannesburg's Migrant Helpdesk.

The importance of the work in the informal sector has been illustrated. A clear, coherent policy to guide the informal economy is currently lacking; such a policy must be created and programmatic support developed (Devey *et al.*, 2006). It is essential that local government recognises the importance of the informal economy and the contribution that international migrants are able to make to local economies, to their own survival, as well as to those that they support and sometimes employ. Local government authorities should work to ensure that the right to employment is upheld, through dissemination workshops and training for local employees and labour-law-enforcement officials. Supportive structures, like the City of Johannesburg's Migrant Helpdesk, must be put in place to benefit international migrants.

### **The role of developmental local government: planning for the future**

HIV and international migration involve all dimensions of urban policy (Thomas, 2003; Balbo & Marconi, 2005), indicating the importance of a "joined-up government" approach (Harrison, 2006, p. 189). This integrated approach reflects increasing awareness of the "ways in which agents are bound together in social, economic and governance networks" (Harrison, 2006, p. 190). Local city governments must develop and implement specific policies to address international migration, particularly since urban policy is the responsibility of local government (Balbo & Marconi, 2005). In addition, local government must work with the relevant provincial authorities as necessary. South Africa gives a developmental mandate to local government: municipalities must work to "proactively shape and influence their local spaces" (Nel & John, 2006, p. 213). While policies favouring the poor may exist, there is a need to actively engage international migrant communities (Balbo & Marconi, 2005). A developmental approach is required, otherwise the poor will remain "socially, economically and environmentally excluded from full urban citizenship" (Parnell & Pieterse, 2007, p. 22). The livelihoods framework presented can assist in identifying the range of government departments that must be involved.

Cities of the future will need to become cosmopolitan places where all residents are comfortable interacting with others (Balbo & Marconi, 2005). Cohesion between all city residents is required for equitable and sustained urban growth; the social fragmentation observed in Johannesburg threatens this and provides an additional challenge to the creation of an 'inclusive city' (Landau, 2007). "Success depends on developing pragmatic, affordable and effective responses to those who find their way into the country and into its cities" (Landau, 2007, p. 73); local government

programmes must incorporate all groups present within the city, coordinate with provincial authorities as necessary, and work to encourage the integration and involvement of all within its systems of livelihood and social welfare.

## Notes

- <sup>1</sup> In this paper, the term 'survivalist livelihood' is used to refer to individuals working in the informal economy during a time of crisis. A period of survival is when individuals are unable to plan far into the future and instead spend their energy surviving day to day. This may be the result of struggling to access the documents required to legalise their stay.
- <sup>2</sup> The research presented here forms part of ongoing doctoral investigation into the persistent urban health challenges of migration and informal settlements in the context of HIV, through which a framework to guide appropriate local-level developmental responses is being developed.
- <sup>3</sup> At the time of writing (June 2008), temporary shelters and 'camps' were established within Gauteng and the Western Cape provinces in response to foreign nationals who were displaced as a result of xenophobic violence. It remains to be seen how long these camps will remain and their longer-term impact.
- <sup>4</sup> The Constitution of the Republic of South Africa (RSA, 1996), The Refugees Act (RSA, 1998a), *The HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011* (Department of Health, 2007a), the National Department of Health's memo (Department of Health, 2006) and revenue directive (Department of Health, 2007b).
- <sup>5</sup> The 2006 African Cities Survey, first undertaken in 2003, was a collaborative project among the following institutions: University of the Witwatersrand (South Africa), Tufts University (USA), the French Institute of South Africa, as well as the following partners: the Centre for Population Studies, Eduardo Mondlane University (Mozambique); Observatory for Urban Change, University of Lubumbashi (Democratic Republic of the Congo); and Institute of Development Studies, University of Nairobi (Kenya).
- <sup>6</sup> A 'piece job' is a short-term, temporary job.
- <sup>7</sup> Fieldwork for the ART access study took place just before the introduction of the September 2007 Directive (Department of Health, 2007b); the ART study was investigating the impact of the 2006 memo (Department of Health, 2006) clarifying that South African identity booklets are not required to access ART in the public health sector.

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**The author** — Joanna Vearey is undertaking a doctoral degree through the School of Public Health at the University of the Witwatersrand. Her research is investigating the persistent urban health challenges of migration and informal settlements in the

context of HIV, through which she is working towards a framework to guide appropriate local-level developmental responses. Her research interests involve numerous aspects of developing-country urban public health.

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